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ABSTRACT

Child welfare services would benefit from a radical rethinking of methods of delivery. As matters now stand, stigmatized services are provided for stigmatized groups (specifically, the children of poor and minority ethnic groups). It is useful to differentiate the social provisions relating to children in need into three categories: (1) truly preventive services, including universal provisions for all children and selective provision for high-risk children; (2) preventive/protective services--in other words, services as presently provided; and (3) "in-care" or substitute care services--for example, child welfare services. Preventive/protective services are likely to be crude, inadequate, ineffectual, and inappropriate. In-care or substitute care services are by definition and design "residualist," or end-of-the-line. Providing services only when a child's primary social support networks break down does not remedy longstanding social ills, nor does it effectively meet new and emerging social needs. Adequate social service provision would remove disadvantages for children and minimize the possibility of deficits. Broadly based community health and social service systems, in which multidisciplinary teams could have access to a wide range of needed resources, could more adequately serve children than could other means of service delivery. While no panacea, universality is the only principle permitting appropriate response on a societal level to modern needs. (RH)

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THE FUTURE OF THE CHILD WELFARE SERVICES IN THE 1980s

Paper prepared for presentation at the
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June, 1980.

The Future of the Child Welfare Services in the 1980s

Much of my recent work has been concerned with the past of the child welfare services in Canada, especially in the period from the late 1950s to the late 1970s. It is therefore difficult for me to look at the future of the services without looking over my shoulder at their past. I have tried to relate the developments of the last twenty years to a number of social, demographic and economic factors. There have been some major changes in this short period of time. Births in Canada declined in number after 1959 and are now some 100,000 less than they were twenty years ago. We now have about 360,000 births annually, a slight rise since 1973. As young people in their early twenties now are numerically at an all time peak we should expect some further rise in the number of births in the next ten to fifteen years, but not necessarily to the peak of twenty years ago.

Despite the fall in the number of births after 1959, the child population aged 0-14 years reached its peak in 1966, and the child population aged 0-19 years in 1969. Furthermore the number of illegitimate births continued to grow until 1970. The number of children in care at one time also reached a peak in 1969/70. In subsequent years the number of children in care has declined, as has the number of completed adoptions.[1] There was also a drop in the number of illegitimate births, but they are on the rise again now.

After 1973 Statistics Canada experienced difficulty in recording illegitimate births, and changed its recording system; this poses problems if we wish to focus on the needs of children born outside the legal framework of marriage. It is however obvious from the record of the number of births to single women, i.e. those never married, that the number of births, whether designated illegitimate or out of wedlock has again started to rise. There are some good demographic reasons why this rise should occur, namely the peaking in the number of young women (and young men) in the 15-24 year age group. Almost fifty per cent of births to single women occurred to the under 20 year age group in 1977, and over eighty per cent to women under 25.[2]

We have two indications again therefore of the type of trends, which directly or indirectly in the past have led to an increase in the work of the child welfare services. There are of course many other factors and confounding variables, which qualify this somewhat simplistic picture of the "supply" side of the child welfare services. To cite only two, (1) unmarried mothers have increasingly opted to keep their babies rather than relinquish them and (2) the development of preventive type, protection services provided in the child's own home can materially reduce the number of children admitted to care. In both these examples these developments do not necessarily reduce the work of the child welfare services, rather they may simply delay and even increase the work of the services.

At this stage I would like to differentiate the social provisions relating to children in need into at least three categories, or stages. The first stage might be categorized as the truly preventive; this stage could be further differentiated into (a) universal provisions needed by all children and (b) more selective provisions needed by high risk children. The second category of provision may be called preventive/protective, and involves the "preventive" child welfare services as we presently know them. The third category can be called the "in-care" or substitute care services.

These three categories require more amplification. Starting with the truly preventive services we are concerned with the well-being of all children, and the maximization of their full potential. We are taking as given that physical and material well-being in childhood is a prerequisite for a full and productive adult life. We assume two benefits from a good start in life, a benefit to the child, and a benefit to the community. We assume also a maximization of the investment made in the child by both parents and society; that is that the benefits far outweigh the costs and that any deficits or disadvantages that occur are kept to a minimum. We can I think begin to see the purpose of universal social programs, be they income support, health services or education. We can also begin to perceive that universal programs do not preclude selective programs, and that the maximization of the benefits does require some searching out of attributes in children, which may warrant more

selective attention, be it of a remedial or a facilitating kind. Moreover given the complexity of the factors involved a range of selective services is required, and virtually all children will qualify for some of these selective services.

An example of selectivity in action may show what I mean. An intelligent child in a middle-class family may be born with a variety of physical conditions, which could, if not remedied, prove to be seriously handicapping in later life, a lazy eye, a mild speech impediment, a slight anomaly in the urinary tract. In addition mild allergic reactions may show up in early childhood, and a number of minor or serious childhood accidents may occur. It is obvious that proper remedial action and care is required by this materially advantaged child. The same of course applies to all children.

The sheer multiplicity of factors and circumstances involved in growing up suggests the need for a much more systematic investment in what I choose to call these truly preventive, universal and selective services. We have a good many of these services in place in one form or another, but we have little reason to suppose that even the universal services are truly adequate for their task. We have not for example fully thought out what we are doing in the area of income support services for children. The existing family allowances, child tax credits and tax exemptions tend to work against each other. The full financial benefits derived from them do not go far enough in providing material support to children in families, and I would say here, in all families. In the case of the poor the benefits are inadequate, and where social assistance is provided, the full amount of the benefits is unlikely to be passed on, even though the basic social assistance payments are insufficient to provide adequate material support and nutrition.

Residualism in the United States and Canada[3]

In a recent American survey wages and other self support were the main sources of support for 40 per cent of the families of children receiving child welfare services; some 38 per cent of families were in receipt of AFDC (i.e. Aid to Families with Dependent Children). Other social programs accounted for a further 13 per cent of these families.[4] For over three quarters of the

estimated 1,800,000 children receiving child welfare services the mother was the principal child care person.

> "The parents of 35 per cent of the children had been married to each other but the marriages had been broken, usually by divorce. The parents of 30 per cent were currently married, and usually living together. The parents of 17 per cent had never been married to each other, and in very few of these cases did they live together. Only 5 per cent of the children had a widowed parent and less than 1 per cent were known to be orphaned. Marital status was unknown for 16 per cent."[5]

The estimated 1.8 million children receiving child welfare services were part of an estimated 3.0 million children receiving public social services.[6]

The American material serves to demonstrate the linkage and the overlap between the child welfare services and the other social services in terms of the population served.

There are striking parallels with the Canadian scene. In terms of children in care or admitted to care approximately 120,000 children were involved in 1976/77 (some of these may represent duplicate admissions in one year, but this number is likely to be quite small). In terms of preventive/protection services Ontario dealt with 83,000 cases in 1976; a fair estimate for the whole country might be 200,000 cases. Some 7,300 of the Ontario children were admitted to care during the year.[7] A conservative estimate of the number of children involved with the child welfare services in one year is 300,000 - this is 5 per cent of all children under the age of 15.

When we look at the income status of low income* single parent families in Canada, we find that

> "approximately 187,000 or 43.7 per cent of single parent families with female heads and 9,000 or 11.7 per cent of single parent families with male heads had in 1977 incomes below the "poverty lines". This compares with an estimated overall incidence of 11.2 per cent for all families in 1977."[8]

About three quarters of the income of low income single parent families comes from government transfer programs and over half for all other low income families. Social assistance amounted to over 40 per cent (43.2) of the income of these single parent families and 11 per cent of other low income families. On average there were two children under the age of 16 years in low income single parent families.

> " . . . in 1977, of the 195,000 "poor" single parent families, approximately 83 per cent had at least one child under 16. In total, there were approximately 332,000 children under 16 in these families. Although all 195,000 families were "poor" in 1977, families with children under 16 (i.e. about 162,000 - my calculation) were considerably worse off than those without children under 16. This can be seen . . . when family size is related to average family income. Not surprisingly, there is a direct relationship between number of children and income inadequacy, the average income per family member declines as the number of children increases."[9]

There appears also to be a relationship between the number of children in a family and the receipt of preventive/protection services. Ontario statistics show a consistently higher average number of children per family in their protection cases than in the general population.[10]

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* For a definition of low income cut-offs or poverty lines see Appendix II of Statistics Canada, Consumer Income and Expenditure Division, Single parent families in Canada, 1977, p. 47.

The American survey reports financial needs and inadequate housing being responsible for children currently receiving service in 22.3 per cent and 13.0 per cent respectively of all reasons given, and being the most important reason in 4.6 per cent and 1.2 per cent of cases respectively.[11] The available Canadian data on reasons for admission to care give the same picture of material factors underlying the more obvious factors of neglect, abuse and parental incapacity. What is also obvious in both the American and Canadian data is the degree of physical, emotional and material disadvantage suffered by many of the families of children receiving services or care. The American survey report argues that by no means all the children were from severely disadvantaged families, but at the same time it points out that financial need was a contributing factor for 400,000 of the 1.8 million children receiving services, and inadequate housing was one of the reasons for service to 233,000 children. At the same time black children numbered 15 per cent of all children under 18 years in the general population and 28 per cent of service recipients.[12]

In Canada we can be sure that financial need and poor housing are important reasons for children receiving child welfare services. At the same time we know that native children are three times more likely to be in care than non-native children, and that they represent about one-fifth of children in care, and this proportion may be increasing.

The point to be made about residualism in social programs is that it does not seem to remedy longstanding social ills, and it is not equipped to meet new and emerging social needs. What we are confronting is a mixture of old and new problems, and we need the most effective tools for helping children in the modern era.

We have a situation therefore of an array of social provisions, which at best do half the job. It is not enough in my view to maintain children and families at subsistence levels. We have to remove the disadvantages for these children, and we have to minimize the possibility of deficits occurring in these children. There is thus a big job to be done in improving the universal income support programs.

Similar criticisms can be made of the other social programs, which are by intent of universal application. In our health services we are still oddly negligent about following all children through early childhood. We rely on perceptive parents for the diagnosis of many handicapping conditions. We wait until accidents occur before becoming alarmed about the possibility of child abuse. Again it is possible to provide good preventive health services for all children, and to provide them not as an imposition on the rights of parents, but rather in cooperation with them. The British "Court" report on child health services argued in favour of "a high general level of service rather than provision of services on the basis of the concept of "priority group".[13]

Again we fall down in our social arrangements for the care and nurture of pre-school children. We have adopted and still adopt a laissez faire approach towards working mothers, and I really should say working parents. By comparison with some other countries we are only at the beginning in devising work leave policies, which cover not only the few weeks around the time of birth or adoption, but also the child's first one, two or three years of life.[14]

The fact is that we are still approaching the social conditions of the late twentieth century with the residualist notions of the late nineteenth century. We talk of major social changes, but fail to adjust our social provisions accordingly. Among these very real social changes is the continued growth in the rate that women participate in the labour force, 23.5 per cent in 1951, 28.7 per cent in 1961, 36.5 per cent in 1971 and 49.6 per cent in December 1979.[15] Both nationally and internationally we have every reason to suppose this trend will continue. We should adjust our child care policies accordingly.

But although there is a strong case for expansion and consolidation of child day care provisions and early childhood education services, I am suggesting that this should be done in coordination with other changes, that do permit parents, if they wish, to devote a good deal of their time to child care duties, when children are very young. We have hardly begun to think in Canada of work sharing, and reduced or staggered hours for husbands and wives.

Universality is, I suggest, the only principle, which permits us to respond appropriately on a societal level to the needs of a modern society. I have suggested already that selectivity is a supplementary or complementary principle, but it cannot be a substitute for universality. Selectivity by itself is the route to renewed residualism, and a patchwork quilt of social provisions, which collectively do not add up to a coherent set of social policies.[16]

The Specialized or Categorical Approach to Child Welfare Services

We still see selectivity at work in most of our child welfare services. The children served are a highly selected population; they qualify for services because they or their families manifest a variety of social needs or social problems. The preventive/protective services are only brought into play, because a problem already exists. But this problem is likely to reflect a set of interacting/interlocking conditions, for which there is no simple or even sophisticated solution.

Moreover the social provisions that can be made in these "problem" situations are likely to be crude, inadequate, ineffectual and what is more inappropriate. The survey already mentioned of American child welfare services summarized the need for more knowledge about the preventive/protective services in this way.

> "Services to children in their own homes - we know that 60 per cent of the children were living with one or both parents, and we know the general types of service they received. But we do not know the actual content of the service, the frequency of service contacts, or the outcome of service."[17]

Basically the preventive/protective services play a surveillance role; they may be able to avert a tragedy, but their main function is as a rationing or screening device, preventing too ready access to in-care services. This function is not as cynical as it may sound, since if there is one thing

certain about child welfare services, it is that the outcome of their interventions is unpredictable. In the long run the cure may be worse than the disease. We rely therefore in fairly large measure on the spontaneous remission of symptoms in the families under surveillance. Our nostrums and panaceas have strictly limited benefits and uses. We come back again, I think, to a realization, that any possible solutions are likely to lie in our broader universal social provisions. Adequate income support and housing policies would help. Good child day care services are a necessity, as are good child health services.

There is a role for child welfare or family welfare workers here, in helping families find the material help they need, when and where they need it. There is a role for public health nurses and teaching homemakers. We cannot and should not ignore the needs of families in distress, but equally we should not approach these needs on too specialist a basis. The child welfare services should be closely integrated with other social services.

The final category of social provisions for children in need I designated earlier as the "in-care" or substitute care services. These services make up what we have traditionally called the child welfare services. They have absorbed most of the allotted resources, and received most policy and research attention, yet they are by definition and design residualist, end-of-the-line services. I have tried to suggest in this paper that the solution to social ills does not lie in residualist, selective provisions. Kadushin and others have argued that in an era of recession and cutbacks we should concentrate our resources on the selective child welfare services.[18] Not only do I think that this is turning the clock back, but we have very little evidence that this is a solution in itself. We should be tackling some social problems on a societal level. We should not perpetuate the role of the child welfare services as the port of last resort.

Whether we like it or not the child welfare services serve primarily the children of the poor and the children of minority ethnic groups. We provide stigmatized services for stigmatized groups. It is tempting to concentrate scarce resources on what appear to be priority needs. But we

have very little reason to suppose that this would be a solution. Rather it would be a political measure, that would delay the improvement of existing universal services.

I am not of course saying that we can abolish the child welfare services. Rather I am arguing that these services should not be expected to carry the main burden of caring for children from families in distress. I think this burden could more adequateiy be borne by more broadly based community health and social service systems, in which multi-disciplinary teams could have access to a wide range of needed resources. In fairness there are some drawbacks to this approach. The American National Study of Social Services to Children and Their Families states the view of some observers that

> "the specialized services, small caseloads, and professionally trained staff characteristic of the former child welfare service units (have been) lost in the new, large, multi-functional agencies. A trend toward the development of "umbrella" agencies at the state and local levels, embracing various combinations of health, welfare, correctional, and other programs in the interests of efficiency has further diminished the stature of specialized child welfare services." [19]

The same criticisms have been expressed in the United Kingdom concerning the merging of child welfare services with other personal social services. The American National Study again identifies one of the root problems

> "Title XX of the Social Security Act, which provides for state planning and administration of social services to dependent families and other special target groups, provides for expanded eligibility for public social services, but such expansion is restricted by a ceiling on federal expenditures for services that has been raised little above the 2.5 billion dollars established in 1973." [20]

The British experience has been the same. The new integrated social services departments (social work in Scotland) were intended to be the main channel of access to a wide range of personal social services intended for all age and need groups. Not surprisingly increased demands for services were experienced, more needs were detected, and new legislation mandated more services. Expanding resources for a brief time partially met the increasing demands, but since the mid-seventies resources have declined, and services have been reduced. What integration means is that the needs of different age and need groups have to be assessed and compared, and resources are then allocated on the basis of agreed priorities. Some greater measure of equity should then be achieved by this distribution of resources. The theory and the reality may of course be very different.

Whether loss of specialization and special skills is bound to occur after integration takes place is quite another question. What may occur, for example, is that people bring real needs, for income support and housing, which are beyond the mandate and the resources of the integrated services to provide. Yet referral to another agency may not be appropriate either. Some dilution of services can result.

There are thus many problems to be overcome. I think the restricted, categorical approach has not served child welfare services particularly well, even though there is need for some highly specialized and skilled workers. Equally the highly bureaucratized and regulated structures of many provincial social service departments do not lend themselves to the ready deployment of a range of needed skills and resources. Although there are many drawbacks to the medical model of service delivery, there are some advantages on the case management side. I think that child welfare services would benefit from radical rethinking of how they are delivered. A progressive step would still in my view be their integration in a wider community service system.

Even though child welfare services are in many provinces part of provincial social services departments, they still tend to form categorical branches, which are poorly integrated with other departmental activities, and which do not have ready access to, nor necessarily make ready use of, other needed services. Children's aid societies have always in my view and in my experience suffered the same functional limitations as provincial services; they have been imperfectly linked with other community services. At the same time all services have operated within severe resource constraints.

The medical model may again provide some illumination. Although there are resource constraints within any health care system, they do not have an immediate effect on the diagnostic and remedial process, and especially where universal access is still a basic principle. Ideally in child welfare services an array of appropriate resources would and should always be available; in reality they are not. Thus selectivity and specialization are not much use without the necessary resources. I have suggested that we should rethink our child welfare services. Perhaps we should not rely so heavily on traditional approaches. Perhaps we should not maintain separate child welfare services at all, but rather link them with other community services.

I have mentioned the medical model, but there are other models available, the universal education system being one of them. It is sixteen years since the Kilbrandon Committee in Scotland suggested a merging of schools and other children's services.[21] The idea was rejected by subsequent governments, but in my view it still has merit. School facilities are well distributed geographically. Their community role is in most cases underdeveloped. They already provide the channel through which a number of health, dental and psychological services are provided. I am trying to suggest that some of our major children's services, and this includes the school system should not remain islands unto themselves. Better integration of services for children at the community level would lead to the creation of more meaningful preventive and supportive services than at present exist.

Of course I am recommending some breaking down of existing service systems and the creation of new community related systems. I see no panacea in this approach. But without radical change I see only a perpetuation of the traditional child welfare services. Frankly I think we can devise better ways of caring for disadvantaged children in their home communities.

Kadushin has bluntly stated the opposing view to the one I hold. His review of the scene in the United States does not greatly differ from mine for Canada. I will quote him at some length

> "Given the reality of limited resources, it may be less visionary but more pragmatic to hold to a residual orientation. An "institutional," "developmental" orientation of the child welfare services system is too ambitious, less efficient and less equitable than a service targeted toward those who need it most. A universally oriented system does have the advantage of being less stigmatizing. But where services are in short supply, as most child welfare services are, priority should be given to those in greatest need. The target population of the child welfare system is not all U.S. children, but those who lack adequate care through the usual caretaking arrangements. Using day care as an example, the reality is in line with a residual orientation even though the rhetoric is "developmental." In all programs of publicly funded day care, "categories" and "eligibility" tend to seep in. Day care gives priority to "children between 3 and 6," or to "low-income parents" or to "AFDC mothers," or to "single-parent, female-headed families," or at least "the working mother." [22]

> "An optimal statement of levels would be that the system seek to provide to the child whatever is needed for the fullest development of individual potential in all areas. At the opposite extreme, the minimal hope is to protect the child from harm.
>
> "The level of objectives is a value question, but one not without realistic constraints. This paper is written at a time of considerable disenchantment and cynicism about social reform programs. . . . Any

statement in this area must be both credible and fiscally responsible. It is best to make modest promises in terms of modest goals, and be modest in proposals for change.[23]

" . . . I suggest that our responsibility lies in establishing or restoring for the client the condition for development that approximates that of his peers living in effectively functioning family units. . . . To promise optimization of the potential of the child receiving child welfare services is to impose on child welfare services a level of achievement rarely attained by intact families generally." [26]

"This is, in general, a rather conservative strategy. It calls for a residual orientation to child welfare services, a remediation rather than a prevention focus, a concern with traditional functions, an emphasis on technical expertise and specialization. It is an exhortation to "think small," to focus concern on clearly defined areas of functional specificity. It suggests that the child welfare services system performs a legitimate, socially useful function in response to community compassion energized by public interest and a concern with social stability. It suggests further that although such functions might be performed by others, they are performed best by professional social workers with specialized training in child welfare service tasks. This point of view reflects my assessment of the situation. It is stated somewhat blatantly and unequivocably so as to define the position precisely, in the hope that it will evoke debate. A clearly stated, definite point of view has the advantage of sharply defining a position for acceptance or rejection." [25]

I have tried to suggest that the danger in the residualist, specialist approach is that we see the trees, but miss the forest. There is nothing finite or absolute about physical abuse and emotional neglect; and even our concepts of poverty are relative. The Canadian evidence suggests that child welfare services expand in response to increased demands and increased

resources. Moreover when the number of births declines, there is not necessarily a consequent reduction in child welfare activity. Rather the penumbra of disadvantage and neglect among children provides ample opportunity for further child welfare work, and this is really the experience of the integrated services in Britain and the United States.

Kadushin calls for modest goals. I agree with him. But the history of our modern social welfare systems suggests that universalist measures have been most effective in addressing the needs of the many poor and disadvantaged people in our societies. The universal programs have their imperfections, and they can be improved. But it is the persistence of residualist notions in the basic income assistance and public housing programs, which has kept the poor in their place. The same could be said about health and education programs, though there are some differences between the United States and Canada.

I have deliberately adopted a somewhat expansionist posture in this paper. I have also stressed the limitations of the traditional child welfare services. I do not think these services should be expected to carry the main burden, moral and material, of caring for a very large number of the nation's most disadvantaged children, and to perform the additional role of policeman in respect of the many more children and families in which some degree of disadvantage and neglect is present. As things stand we allot insufficient resources for the carrying of this burden and the discharge of this role. Moreover there is very little evidence that "after the fact" services, which is what the child welfare services largely are, provide any kind of solution. I do not expect a complete or total solution can be found, but a more universalistic underpinning of social programs concerned with childhood, especially early childhood would help. Because we are in a period of economy recession does not remove from us the responsibility for devising better social policies.

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